CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 635

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: AUGUST 5, 2005

Change Request 3948

SUBJECT: Financial Liability for Services Subject to Home Health Consolidated Billing

I. SUMMARY OF CHANGES: This transmittal reorganizes and clarifies instructions regarding home health consolidated billing, particularly with regard to liability for payment. The transmittal also adds to the manual information on this subject previously published in provider education articles attached to Program Memoranda.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : October 1, 2000

IMPLEMENTATION DATE : November 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/Table of Contents
D	10/10.1.25/HH PPS Consolidated Billing and Primary HHAs
R	10/20/Home Health Prospective Payment System (HH PPS) Consolidated Billing
R	10/20.1/Beneficiary Notification and Payment Liability Under Home Health Consolidated Billing
N	10/20.1.1/Responsibilities of Home Health Agencies
N	10/20.1.2/Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing
N	10/20.1.3/Responsibilities of Hospitals Discharging Medicare Beneficiaries to Home Health Care
R	10/20.2/Home Health Consolidated Billing Edits in Medicare

	Systems
N	10/20.2.1/Non-routine Supply Editing 10/20.1.2/Therapy Editing
N	10/20.1.2/Therapy Editing
N	10/20.2.3/Other Editing Related to Home Health Consolidated Billing
N	10/20.2.4/Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days After RAP Start Date
N	10/20.2.5/No RAP Received and Therapy Services Rendered in the Home
R	10/30.1/Health Insurance Eligibility Query to Determine Episode Status
R	10/30.8/Other Editing and Changes for HH PPS Episodes
R	10/30.9/Coordination of HH PPS Claims and Episodes With Inpatient Claim Types

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 635	Date: August 5, 2005	Change Request 3948

SUBJECT: Financial Liability for Services Subject to Home Health (HH) Consolidated Billing

I. GENERAL INFORMATION

A. Background: This change request provides manual instructions specifying circumstances in which providers or beneficiaries may be liable for payment for services subject to HH consolidated billing. Previous guidance on this subject has been provided in provider education Program Memoranda. This change request updates Medicare manuals to reflect this guidance and elaborates on it. It also improves the organization of existing manual sections regarding HH consolidated billing.

B. Policy: No changes are being made to the policy regarding HH consolidated billing. The manual revisions in this instruction simply reflect current policy more fully and accurately.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3948.1	Contractors shall educate staff regarding of the revisions made to HH consolidated billing sections of Chapter 10 of Pub.100-04, Medicare Claims Processing Manual.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3948.2	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2000 **Implementation Date:** November 3, 2005 **Pre-Implementation Contact(s):** Wil Gehne, (410) 786-6148 or Yvonne Young (410) 786-1886 **Post-Implementation Contact(s):** Regional Offices	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Claims Processing Manual

Chapter 10 - Home Health Agency Billing

Table of Contents

(Rev. 635, 08-05-05)

Crosswalk to Old Manual

20 - Home Health Prospective Payment System (HH PPS) Consolidated Billing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

HH-467.35, A3-3639.35, PM-AB-00-112, PM AB-01-65, PM-AB-01-111, PM A-02-104, PM A-02-106, PM B-03-021

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare payment for all such items and services is to be made to a single home health agency (HHA) overseeing that plan. This HHA is known as the primary HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or "otherwise." Payment for all items is included in the HH PPS episode payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- *Skilled nursing care;*
- *Home health aide services;*
- *Physical therapy;*
- *Speech-language pathology;*
- *Occupational therapy;*
- *Medical social services;*
- *Routine and nonroutine medical supplies;*
- *Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of an HHA that is affiliated or under common control with that hospital; and*
- *Care for homebound patients involving equipment too cumbersome to take to the home.*

Exception: Therapy services are not subject to the home health consolidated billing methodology when performed by a physician.

Medicare periodically publishes Routine Update Notifications that contain updated lists of nonroutine supply codes and therapy codes that must be included in home health consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes, which Medicare also publishes annually. The lists may also be updated as frequently as quarterly if this is required by the creation of new HCPCS codes mid-year.

The HHA that submits a Request for Anticipated Payment (RAP) or No-RAP LUPA claim successfully processed by Medicare claims processing systems will be recorded as the primary HHA for a given episode in the Common Working File (CWF). If a beneficiary

transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. Contractors will reject any claims from providers or suppliers other than the primary HHA that contain billing for the services and items subject to consolidated billing when billed for dates of service within an episode, from the first day of that episode until day 60 or last billable service date, if discharged. This applies to claims from provider types including and beyond HHAs (e.g., outpatient hospital facilities, suppliers). Contractors will also reject claims subject to consolidated billing when submitted by the primary HHA as services not under an HH plan of care (using type of bill 34x) when the primary HHA has already billed other services under an HH plan of care (type of bill 32x) for the beneficiary. Institutional providers may access information on existing episodes through the home health CWF inquiry process. See §30.1.

Durable Medical Equipment (DME) is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier to a Durable Medical Equipment Regional Carrier (DMERC) or billed by an HHA (including HHAs other than the primary HHA) to an RHHI. Refer to §90. Medicare claims processing systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted to both the FI and the carrier for the same dates of service for the same beneficiary. In the event of duplicate billing to both the RHHI and the DMERC, the first claim received will be processed and paid. Subsequent duplicate claims will be denied. Medicare claims processing systems will also prevent payment for the purchase and the rental of the same item for the same dates of service. In this event, the first claim received, regardless of whether for purchase or rental, will be processed and paid.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis, in addition to episodes payments, and are billed on a claim with a bill-type that is not specific to HH PPS (TOB 34X). When an HH episode is open for a specific beneficiary, only the primary HHA serving the beneficiary will be permitted to bill osteoporosis drugs for them. For more detailed information, refer to §90.1.

20.1 - Beneficiary Notification and Payment Liability Under Home Health Consolidated Billing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

20.1.1 -- Responsibilities of Home Health Agencies

PM A-02-104

Medicare payment for services subject to home health consolidated billing is made to the primary HHA, so separate Medicare payment for these services will never be made. The primary HHA is responsible for providing these services, either directly or under arrangement. This responsibility applies to all services that the physician has ordered on the beneficiary's home health plan of care.

However, providing services either directly or under arrangement requires knowledge of the services provided during the episode. An HHA would not be responsible for payment to another provider in the situation in which they have no prior knowledge (e.g., they are

unaware of physicians orders) of the services provided by that provider during an episode to a patient who is under their home health plan of care.

In certain circumstances where the primary HHA is unaware of services provided during the episode and the beneficiary is properly notified, the beneficiary may be liable for payment for these services. In order to protect the beneficiary from unexpected liability in these cases, and in order to comply with Medicare Conditions of Participation, it is important that all providers and suppliers serving a home health patient notify the beneficiary of the possibility that they will be responsible for payment.

Notification about home health consolidated billing must begin with the beneficiary's admission to home health care. Under the Medicare Home Health Services Conditions of Participation: ***Patient rights****, (42 CFR, §484.10 (c) (i)), the HHA must advise the patient, in advance, of the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will furnish care, and the frequency of visits proposed to be furnished. It is, therefore, the responsibility of the HHA to fully inform beneficiaries that all home health services, including therapies and supplies, will be provided by his/her primary HHA.*

In addition, under the Conditions of Participation: ***Patient liability for payment****, (42 CFR, §484.10(e)), HHAs are responsible for advising the patient, in advance, about the extent to which payment is expected from Medicare or other sources, including the patient. Information regarding patient liability for payment must be provided by the HHA both orally and in writing. This should assist in alerting the beneficiary to the possibility of payment liability if he/she were to obtain services from anyone other than their primary HHA.*

20.1.2 - Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

PM B-03-021

Since Medicare payment for services subject to home health consolidated billing is made to the primary HHA, providers or suppliers of these services must be aware that separate Medicare payment will not be made to them. Therefore, before they provide services to a Medicare beneficiary, these providers or suppliers need to determine whether or not a home health episode of care exists for that beneficiary. This information may be available to providers or suppliers from a number of sources.

The first avenue a therapy provider or a supplier may pursue is to ask the beneficiary (or his/her authorized representative) if he/she is presently receiving home health services under a home health plan of care. Additionally, information about current home health episodes may be available from Medicare contractors. Institutional providers (providers who bill fiscal intermediaries) may access this information electronically through the home health CWF inquiry process (See §30.1). Independent therapists who bill Medicare carriers or suppliers who bill DMERCs will gain access to a similar electronic inquiry in the future. In the interim they may, as a last resort, call their contractor's provider toll free line to request home health eligibility information available on the Common Working File. The carrier's or DMERC's information is based only on claims Medicare has received from home health agencies at the day of the contact. Beneficiaries and their

representatives should have the most complete information as to whether or not they are receiving home health care. Therapy providers or suppliers may, but are not required to, document information from the beneficiary that states the beneficiary is not receiving home health care, but such documentation in itself does not shift liability to either the beneficiary or Medicare.

If a therapy provider or a supplier learns of a home health episode from any of these sources, or if they believe they don't have reliable information, they should advise the beneficiary that if the beneficiary decides not to have the services provided by the primary HHA and the beneficiary is in an HH episode, the beneficiary will be liable for payment for the services. Beneficiaries should be notified of their potential liability before the services are provided.

If a therapy provider or a supplier learns of a home health episode and has sufficient information to contact the primary HHA, they may inquire about the possibility of making a payment arrangement for the service with the primary HHA. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to providers involved and to Medicare beneficiaries.

20.1.3 - Responsibilities of Hospitals Discharging Medicare Beneficiaries to Home Health Care

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

PM A-02-106

*A hospital discharging a Medicare beneficiary to home health care can also play an important role in alerting the beneficiary to their potential liability under home health consolidated billing. Under the Medicare Conditions of Participation (COP) for Hospitals: **Discharge planning,** (42 CFR, §482.43 (b) (3) and (6)), hospitals must have in effect a discharge planning process that applies to all patients, and the discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and the hospital must discuss the results of the evaluation with the patient or individual acting on his or her behalf. In addition, under 42 CFR, §482.43 (c) (5), the patient and family members must be counseled to prepare them for post-hospital care and under 42 CFR, §482.43 (d) **Transfer or referral,** the hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.*

*Hospitals, therefore, should counsel beneficiaries being discharged to receive home health services, that his/her "primary" home health agency; i.e., the agency establishing his/her plan of care, will provide all home health services. Hospitals should provide a list of home health agencies for beneficiaries to choose from; in addition, when referring the beneficiary to his/her chosen home health agency, the hospital should notify the agency and include any counseling notes, which should serve as a reminder to the home health agency to also notify the beneficiary that **all** home health services will be provided by them as the "primary" home health agency. Hospitals play a key role in making*

beneficiaries, and/or their caregivers, aware of Medicare home health coverage policies to help ensure that those services are provided appropriately.

20.2 - Home health Consolidated Billing Edits in Medicare Systems

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

In short, consolidated billing requires that only the primary HHA bill services under the home health benefit, with the exception of DME and therapy services provided by physicians, for the period of that episode. The types of service most affected are nonroutine supplies and outpatient therapies, since these services are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

Home health consolidated billing editing is applied when the episode claim has been received and processed in CWF. Edits are applied if the claim subject to consolidated billing contains dates of service between and including the episode start date and the last billable service date for the episode if the patient is discharged or transferred. If the patient is not discharged or transferred, the episode end date is used for editing purposes. Any line item services within the episode start date and last billable service date or episode end date, whichever is appropriate for the patient status, will be edited. CWF sends information to FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing.

Claims subject to consolidated billing may be identified in one of two ways. Claims may be edited when the HH PPS claim had been received before the claim for services subject to consolidated billing. In these cases, the line items subject to consolidated billing are rejected or denied prior to payment. Claims may also be identified when the HH PPS claim is received after the other claims subject to consolidated billing. In these cases, the claim for services subject to consolidated billing has already been paid. CWF then notifies the FI or carrier to make a post-payment rejection or denial.

For post-payment rejections of claims billed to FIs, recoveries will be made automatically in the claims process. For post-payment rejections of claims billed to carriers, carriers will follow their routine overpayment identification and recovery procedures. In the event a denial is reversed upon appeal, an override procedure exists to permit payment to be made.

Whether a claim for services subject to consolidated billing is identified pre- or post-payment, messages explaining line-item actions for home health consolidated billing appear on remittance advice for providers and Medicare Summary Notices (MSNs) for beneficiaries.

Claims subject to home health consolidated billing receive the following remittance advice codes:

- *Reason Code B15: "Payment adjusted because this procedure/service is not paid separately"*
- *Remark Code N70: "Home health consolidated billing and payment applies"*

Since home health consolidated billing is not an ABN situation, coding on incoming claims cannot allow Medicare systems to fully identify the payment liability for any

denial. As described in §20.1, whether the denial is the liability of the primary HHA or the beneficiary is determined by whether the services are provided under arrangement and whether the beneficiary received notice of their potential liability. These denials are shown as provider liability on remittance advices (group code CO) to ensure therapy providers or suppliers explore whether a payment arrangement exists or can be made for the services. Despite this coding limitation, Medicare recognizes that ultimately beneficiaries may be liable for these services.

20.2.1 - Nonroutine Supply Editing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

For home health consolidated billing, nonroutine medical supplies are identified as a list of discrete items by HCPCS code in the final rule for HH PPS. This list will be updated periodically by Routine Update Notification. When an open HH PPS episode exists at CWF, any claim with a nonroutine supply HCPCS code that is submitted to a DME Regional Carrier with dates of service that overlap the episode dates will be denied.

Claims submitted to fiscal intermediaries for certain emergency, surgical, diagnostic, and end stage renal disease (ESRD) services may include a nonroutine supply HCPCS code in addition to the other services provided. Because these supplies are either bundled into the rate paid for the primary service or are otherwise incident to the primary service(s) being rendered, these supplies do not fall within the bundling provisions of HH PPS. These claims are not subject to consolidated billing edits by CWF.

20.2.2 - Therapy Editing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

On claims submitted to fiscal intermediaries, CWF enforces consolidated billing for outpatient therapies, recognizing as therapies all services billed under revenue codes 042X, 043X, 044X. These revenue codes have been cross-referenced to a list of HCPCS codes which represent the same services for use in editing against carrier claims. This list will also be updated periodically by Routine Update Notification.

Therapy services are not subject to the home health consolidated billing methodology when performed by a physician. Therefore, CWF bypasses the therapy edit if the HCPCS code is a therapy code subject to home health consolidated billing but the specialty code on the claim indicates a physician.

20.2.3 - Other Editing Related to Home Health Consolidated Billing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

CWF edits to prevent duplicate billing among RHHIs and DME regional carriers. Consequently, CWF must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though HH consolidated billing does not apply to DME by law.

If revenue code 0636 and the HCPCS code for an osteoporosis drug is billed on a 34X bill type claim during an open HH episode, CWF must edit to ensure that the provider of the 34X bill is the same as the primary provider of the open episode, since by law

consolidated billing must also be applied to the osteoporosis drug even though this item is paid outside of the episode payment. HH consolidated billing will not affect billing of DME or services outside the home health benefit, even when these services are billed by HHAs.

20.2.4 - Only Request for Anticipated Payment (RAP) Received and Services Fall Within 60 Days after RAP Start Date

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

PM-AB-01-70, Dated 5/1/01

If only a RAP for the episode has been received and the incoming claim with services subject to consolidated billing contains dates of service within the full 60-day home health episode period, CWF returns an alert to the FI or carrier to notify them that the claim may be subject to consolidated billing. The FI or carrier processes the claim to payment, but passes on the alert to the provider on the remittance advice that accompanies the payment in the form of the following remark code:

> *N88 - "This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under an HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, will be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."*

This remark code is applied at the line level on the electronic remittance advice. It indicates to providers that the services may be denied and claim payment may be recouped if later editing or another post-payment recovery process identifies the claim as subject to consolidated billing. No message reflecting the alert is displayed to the beneficiary on the Medicare Summary Notice.

20.2.5 - No RAP Received and Therapy Services Rendered in the Home

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

PM B-02-050

There may be situations in which a beneficiary is under a home health plan of care, but CWF does not yet have a record of either a RAP or a home health claim for the episode of care. To help inform independent therapy providers billing carriers that the services they rendered in the home setting may be subject to consolidated billing, providers will receive the following remark code on the remittance advice when Medicare pays them for the service:

> *N116 - This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.*

Carrier systems will provide this message when the place of service on the claim is "12 home," the HCPCS code is a therapy code subject to home health consolidated billing and CWF has not returned a message indicating the presence of a RAP.

30.1 - Health Insurance Eligibility Query to Determine Episode Status

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

HH-467.17, HH-468, A3-3639.17, A3-3640, A3-3508, PM AB-03-036

With the advent of HH PPS and home health consolidated billing (described elsewhere in this chapter), one HHA is considered the "primary" home health agency in billing situations. This primary agency is the **only** agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. When a homebound beneficiary seeks care from an HHA *or from an institutional therapy provider subject to home health consolidated billing*, the *provider needs* to determine if the beneficiary is already being served by *an HHA* - an agency that then would be considered primary.

HHAs *or institutional therapy providers* may send an inquiry to determine the beneficiary's entitlement and eligibility status into the Common Working File or CWF, through their RHHI. Effective October 16, 2003, they must send the ANSI X12N 270 transaction set and will receive the ANSI X12N 271 transaction set in response, in order to comply with the requirements of the Health Insurance Portability and Accountability Act.

RHHIs *or FIs* will create an ELGH record from the 270 to request this data from CWF and will receive the ELGA record from CWF in response. The RHHI *or FI* will create the 271 response or DDE screen from the ELGA transaction record.

The response shows whether or not the beneficiary is currently in a home health episode of care. If the beneficiary is not already under care at another HHA, he/she can be admitted to the inquiring HHA, and that agency will become primary. The beneficiary can also be admitted even if an episode is already open at another HHA **if** the beneficiary has chosen to transfer.

See Chapter 31 for a description of the data elements and related requirements.

30.8 - Other Editing and Changes for HH PPS Episodes

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

HH-468.8, A3-3640.8

CWF assures that the final "*through* date" on the episode claim equals the calculated period end date for the episode if the patient status code for the claim indicates the beneficiary remains in the care of the same HHA (patient status code 30). If the patient dies, represented with a patient status code of 20, the episode does not receive a PEP adjustment, though other adjustments may apply, but the through date on the claim indicates the date of death instead of the end of the episode period. When the patient status of a claim is 06, indicating transfer, the episode period end date is adjusted to reflect the "through date" of that claim, and payment is also adjusted. When the status of the claim is 01, no change is made in the episode length or claims payment unless a separate RAP or claim is received which overlaps that 60-day period and contains either a transfer or discharge and readmit indicator.

CWF also acts on source of admission codes on RAPs. For example, CWF acts on "B," indicating transfer, and "C," indicating readmission after discharge by the same agency in the same 60-day period, open new episodes. In addition to these two codes, though, any approved source of admission code may appear, and these other codes alone do not trigger creation of a new episode. CWF recognizes internal action codes, generated by the Medicare claims processing systems, and cancel-only codes, assigned by CMS, that have been assigned to specific HH PPS transactions and situations to aid in processing these claims.

30.9 - Coordination of HH PPS Claims Episodes With Inpatient Claim Types

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

HH-468.9, A3-3640.9

Claims for institutional inpatient services, that is inpatient hospital and skilled nursing facility services, will continue to have priority over claims for home health services under HH PPS. Beneficiaries cannot be institutionalized and receive home care simultaneously. Thus, if an HH PPS claim is received, and CWF finds dates of service on the HH claims that fall within the dates of an inpatient or skilled nursing facility (SNF) claim (not including the dates of admission and discharge), the RHHI will reject the HH claim. This would still be the case even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later, but contained dates of service duplicating dates of service within the HH PPS episode period.

A beneficiary does not have to be discharged from home care because of an inpatient admission. If an agency chooses not to discharge and the patient returns to the agency in the same 60-day period, the same episode continues, although a SCIC adjustment may apply. Occurrence span code 74, previously used in such situations, should not be employed on HH PPS claims. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same 60-day period, there would be one shortened

HH PPS episode completed before the inpatient stay ending with the discharge, and another starting after the inpatient stay, with delivery of home care never overlapping the inpatient stay. The first shortened episode would receive a PEP adjustment only because the beneficiary was receiving more home care in the same 60-day period. This would likely reduce the agency's payment overall.